THE HOLE IN THE WALL GANG CAMP

2012 Camper Application Packet

Dear Parents and Guardians,

Welcome to the 2012 application for Camp! THE HOLE IN THE WALL GANG CAMP provides a residential summer camp experience at **no charge** for children with a diagnosis of cancer, a serious blood disease, acquired or hereditary immune disorder, or metabolic disease. Medical care is provided by on-site pediatric doctors and nurses. Please read all the information enclosed as our application has changed.

To attend Camp your child must:

1. Have a diagnosis of cancer, a serious blood disease, acquired or hereditary immune disorder, or metabolic disease. In certain cases we can accept children with other unique medical needs. Please contact us with questions.
2. Be age 7 to 15
3. Live in New England, New York, or New Jersey. Campers from other areas are included when possible.
4. Be medically unable to attend any other camp.

To provide a camping experience for as many different children as possible, we ask that your child attend only one of Hole in the Wall Gang Association Camps.

Sending an application does not guarantee your child will be attending camp. All applications are reviewed by the medical team. Acceptance is based on criteria including the medical needs of the child and our ability to provide safe and appropriate programming for your child.

2012 Summer Sessions:

Session	Type	Dates
Session 1	General	June 6 to June 12
Session 2	General	June 15 to June 21
Session 3	Sickle Cell	June 24 to June 30
Session 4	Immunology	July 3 to July 9
Session 5	General	July 13 to July 19
Session 6	Sickle Cell	July 22 to July 28
Session 7	General	August 1 to August 7
Session 8	General	August 10 to August 16
Session 9	Brother/Sister	August 19 to August 25

Brothers and sisters of campers who attend Sessions 1-8 who live in New England will receive an application in June to apply for the Brother & Sister Session. Those living outside this area may request an application by contacting the Camp office. Children applying for this session must be between the ages of 7 and 15 and must not have a diagnosis that would make him/her eligible for our other sessions. Brothers and Sisters attend this session separately from their diagnosed sibling.

APPLYING TO CAMP

The application must be complete before it can be reviewed. A complete application contains three (3) parts. Please note that incomplete information will delay your application. We appreciate your timely response in obtaining missing information. **Applications are due April 1, 2012.**

PART I – General Information: to be completed by Parent or Guardian

a. General Information: name and contact information
b. Signed consent for medical treatment
c. Insurance Information
d. Photo release and special permissions

PART II – Questionnaire: to be competed by Parent or Guardian

PART III – Medical Information: to be completed by child's Medical Provider, Specialist, Primary Care Physician or Nurse Practitioner

a. Medical Form: general medical information, medications, and immunizations
b. Medical Disease Specific Form
c. Catheter or Infusion Pump Form: if applicable

We would like to accept every child who applies to Camp, but it is impossible to do so. All applications are medically reviewed. Decisions are made based on the child's inability to attend a typical camp, the severity of the child's medical need, whether the child has been to Camp before. Camp also reserves the right to make selections/decisions based on other factors as deemed appropriate.

If your child is applying to Camp as part of a group, please return the application to your group coordinator; they will be responsible for sending your application to Camp.

Acceptances will be mailed after May 1, 2012. If your child is placed on a waiting list, you will be contacted when space becomes available.

Applications may be sent through mail or fax*:

The Hole in the Wall Gang Camp
565 Ashford Center Road
Ashford, Connecticut 06278

Phone: (860) 429-3444
*Fax: (860) 429-7295
Email: Ashford@holeinthewallgang.org
Web: www.holeinthewallgang.org

* Please call Camp office to confirm fax has been received

Questions?

Medical:
Dr. Sharon Space, M.D., Medical Director
Sharon.space@holeinthewallgang.org
(860) 429-3444 ext. 191

Admissions:
Cristina Sapoval, MPS HRM, Director of Camper Admissions
Cristina.sapoval@holeinthewallgang.org
(860) 429-3444 ext. 123

THE HOLE IN THE WALL GANG CAMP
565 ASHFORD CENTER RD
ASHFORD, CT 06278
TEL: (860) 429-3444 FAX: (860) 429-7295

Session Request:
(Choice of session not guaranteed)

1st Choice: Session __________

2nd Choice: Session ___________

PART I- GENERAL INFORMATION
TO BE COMPLETED BY PARENT OR GUARDIAN

Child's First Name ________________________________ M.I. ____ Last Name _________________________________

Gender _______ Age _______ Birthdate ___________________ Nickname ___________________ Grade in School ______

Phone (   ) _____________________________Email Address____

Address____________________________________ Apt ____City ___________________State ______Zip_____________

County _________________________ Country _____________________ Place of Birth __________________________

Primary Language ____ Does he or she speak English? □ Yes □ No

DIAGNOSIS _________________________ Date of Diagnosis ____________ Is child aware of diagnosis? □ Yes □ No

Hospital Affiliation ____ Telephone _____________________________

Social Worker Name ____ Telephone _____________________________

Has the Child Previously Attended The Hole in the Wall Gang Camp? □ Yes When? _______________________ **□ No**

How did you hear about Camp? □ Medical Provider □ Hospital Outreach □ Website □ Camp Day □ Other _______________

How are you getting to camp?: □ Family □ Clinic Group/Bus □ Other_________________________________

NAME OF PARENT(S) OR LEGAL GUARDIAN(S)				
First and Last Name:	**Relationship:**	**Legal Custody?**	**Home Phone:**	**Cell Phone:**
		□ Yes □ No		
		□ Yes □ No		
		□ Yes □ No		

Who does the child live with? ____

BROTHERS AND SISTERS (AGES 7 – 15 only)					
First and Last Name:	**Birthdate:**	**Gender:**	**First and Last Name:**	**Birthdate:**	**Gender:**

IMPORTANT REQUIRED INFORMATION

EMERGENCY CONTACT

Person to be contacted in case of emergency if parent or guardian cannot be reached:

Name ____Relationship to child _____________________________________

Home phone (   ) __________________Work Phone (   ) ___________________Cell Phone (   ) __________________

Name/phone of person authorized to pick up your child if unavailable on closing day ___________________________

AUTHORIZATION TO PROVIDE MEDICAL, DENTAL AND SURGICAL TREATMENT

Camper Name: ____ **Birthdate** ____________________

I hereby authorize the Medical Director of The Hole in the Wall Gang Camp or such designee or designees as the Medical Director may appoint, to provide for the giving of emergency medical care or treatment, including medicines, immunizations, x-rays, tests, dental and minor surgical treatment, hospitalization, general anesthesia or other medical treatment as may be appropriate while the child is in the care of The Hole in the Wall Gang Camp. Notification of the parent will always be attempted. I understand that information pertaining to my child may be shared with/released to appropriate personnel for the purpose of treating and/or supervising my child (including, but not limited to camp staff, referral centers and/or insurance companies). I further agree that this authorization includes the administration of all prescribed medications and treatments previously listed in this application and shall be effective until revoked.

__________ ____________________________________ ___________________________________

Date **Signature of Parent/Guardian** ***(signature is mandatory)*** **Relationship to Child**

____

Print Name

INSURANCE INFORMATION

(To be used for special tests, x-rays or medical consultations)

Please complete or attach a copy of child's insurance information

Name of Insurance Company ____

Policy Number or CIN# ____

Medicaid Number (if applicable) ____

Address ____

Phone Number ____

Prescription Plan (Co, ID#) ____

If group insurance, specify company ____

Name of parent who insures child ____

PHOTO RELEASE PERMISSION

I do _____ do not _____ give The Hole in the Wall Gang Camp permission to photograph and use pictures of

____ in professional fund raising activities.

Name of child

The philosophy of The Hole in the Wall Gang Camp is to photograph children infrequently. With this permission, camper photographs may be included in a bulletin board, newsletter, video, internet or camp album. Camp respects the privacy of its campers and does not allow unauthorized visitors to photograph the camp or campers**.**

____ ________________________

Signature of Parent or Guardian **Date**

Unit and cabin pictures may be taken and distributed to each child. If you wish your child to participate and receive a photograph please initial here __________.

PART II- QUESTIONNAIRE

TO BE COMPLETED BY PARENT OR GUARDIAN

Camper Name: ____ **BIRTHDATE:**____________________

The following information is very important to your child's enjoyment of and success in our Camp program. Please answer honestly and to the best of your ability. Please attach additional pages if necessary. Thank you very much.

______________________________________ ______________________________________

Name of person completing this form **Relationship to child**

Does your child understand and follow simple directions? □ Yes □ No □ Sometimes
If you answered No or Sometimes, please explain: ____

____

Does your child use words to express needs and feelings? □ Yes □ No If No, please explain: ______________________

____

Does your child speak in full sentences? □ Yes □ No

What grade is your child in?________ Has your child repeated a grade? □ Yes □ No If yes, which grade? ______________

Is special help given to your child in school? □ Yes □ No If Yes, what kind of help and for what reason?

____

____

Have there been any stressful life events in the past year? □ Yes □ No
If Yes, please explain: ____

____

____

What, if any, concerns do you or others that care for your child have about his/her behavior?

____

____

____

Has your child ever seen a therapist or psychiatrist? □ Yes □ No
If Yes, what type of counselor and for what purpose? ____

____

____

In the last 12 months has your child taken medication for behavioral or mental health concerns? □ Yes □ No

How does your child get along with other children? (taking turns, group activities, disputes)

____

____

Does your child have specific fears, anxieties or worries? □ Yes □ No If Yes, what are they?

____

____

What are your child's strengths? ____

____

____

While at Camp, how can we help make your child feel secure and comfortable? ______________________

____

____

Tell us about your child's bedtime routine. (How do you put them to bed?)______________________

____

Has your child ever successfully slept away from home before?

____

____

Is there anything special that your child may want to do at Camp? Anything he or she will not want to do?

____

____

____

LEVEL OF ASSISTANCE FOR YOUR CHILD PLEASE CHECK (√)APPROPRIATE COLUMN(S)				
	Independent	Close Supervision	Moderate Assistance	Total Care
Daily Care (brushing teeth, combing hair, dressing)				
Meals				
Bathing/ Showering				
Toileting/ Bathroom				

If you wish for us to contact another professional concerning your child, please complete contact information here:

Name______________________________ Address______________________________

Phone______________________________ Email______________________________

I give permission for The Hole in the Wall Gang Camp to speak to the above named professional solely for the purpose of gathering information regarding eligibility for Camp and to plan for my child's success at Camp:

Parent or Guardian Signature: ____

Print Name Here: ____

Date: ____

(Note: Release of information consent expires on December 31, 2012)

PART III- MEDICAL FORM
TO BE COMPLETED BY HEALTH CARE PROVIDER

NAME OF PHYSICIAN WHO SHOULD BE CONTACTED	
Specialty Dr:	Pediatrician/Other Dr:
Hospital:	Hospital:
Address:	Address:
Phone:	Phone:
Emergency Phone:	Emergency Phone:
Pager:	Pager:

GENERAL INFORMATION:

Camper Name: ______________________ Birthdate: ______________ Date: ______________

Primary Diagnosis: ______________________________ Date of Diagnosis: ______________

Please List Current Problem(s) or Secondary Diagnoses: Comments:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Is this child currently receiving treatment? □ Yes □ No If Yes, please explain: ______________________

____

Drug Allergies: ____

Food Allergies: ______________________ Other Allergies: ______________________

Does this child have:

- Central Venous Catheter □ Yes □ No If Yes, please complete CV Catheter Form
- G-tube/J-tube □ Yes □ No If Yes, please complete Infusion Pump Form
- TPN □ Yes □ No If Yes, please complete Infusion Pump Form
- IV or subcutaneous medications □ Yes □ No If Yes, please explain below

Explanation: ____

____

Please list all surgeries and dates: ______________________________

____

Physical disability or limitations affecting any camp activity: □ Yes □ No If Yes, please explain, including use of braces, wheelchair, crutches, artificial limbs, or other mobility aids. ______________________

____

Is the child's development appropriate for his or her age? □ Yes □ No If No, at what age does child function? __________

Are there any behavior problems that would affect child's participation in a group? □ Yes □ No If Yes, please describe:

____

Pertinent Psychosocial Information: ______________________________

____

____

PHYSICAL EXAM: Please list any pertinent physical findings or attach a recent history & physical.

Height: Ft ________ Cm ________ Weight: Lbs ________ Kg ________ BP ______________

Pertinent findings: ____

____

____

IMMUNIZATIONS: Please complete the chart below with dates or attach a copy of the immunization history.

Camper Name: ______________________ Birthdate: ______________ Date: ______________

DTP/ DTap	1	2	3	4	5
Tetanus Booster	1				
IPV/ OPV	1	2	3	4	
Hib/ H. Flu	1	2	3	4	
Hepatitis B	1	2	3		
Pneumococcal	1	2	3	4	
Varicella	1	2			
Other	1	2	3	4	5

Varicella History:
Is this child immune to varicella? □ Yes □ No
If yes: □ Clinical disease Date ____________
□ By immunization
□ Positive titers

Measles, Mumps, and Rubella: A series of two vaccinations REQUIRED unless exempt contraindicated by disease.
MMR 1 ____________________ MMR 2 ____________________
Exempt? □ Yes Why? ____

MEDICATIONS:
Complete Physician's order is required for all medications including OTC medications that will be administered at camp.

Name of Medicine	Dose	Route	Frequency

Essential laboratory studies to be done while child is at camp ____

Are there any special suggestions or restrictions for this camper? ____

PHYSICIAN'S STATEMENT: I have examined ______________________________ and find him or her physically able to attend Camp. I understand the above medical regimen will be followed while the camper is at Camp.

Signature of Provider ____________ Print Name ____________ Date ____________

Clinic / Day Phone ____________ Emergency / On Call Phone ____________

PLEASE COMPLETE MEDICAL DISEASE SPECIFIC FORM ON THE NEXT PAGE

MEDICAL DISEASE SPECIFIC FORM

TO BE COMPLETED BY HEALTH CARE PROVIDER

Please complete applicable sections below

Children with Cancer: **Camper Name:**_______________________**Birthdate**__________**Date:**______________

Diagnosis: ____ Date of Diagnosis: _________________________

Date of relapse (if applicable) ______________________

Is the child still on treatment? □ Yes □ No If Yes, please give details of most recent chemotherapy (date, meds):

____

____

If not, date chemotherapy was completed: ____

Has the child has a stem cell transplant? □ Yes □ No Date: ____

Does the child have long term side effects from his or her treatment or disease? □ Yes □ No

If Yes, please explain: ____

____

Most recent or typical blood counts: Date __________________________

Hb ________ Hct ________ WBC ________ ANC ________ Plt ________

Children with Sickle Cell Disease: **Camper Name:**_____________**Birthdate**__________**Date:**__________

What hemoglobinopathy does the child have? (SS, SC, etc.) ____

What complications has the child had?

	Yes	No	Comments
Frequent VOC			
Acute Chest Syndrome			
Stroke			
AVN			
Priapism			
Splenic Sequestration			
Bacteremia/Infection			
Gallstones			
Sleep Apnea			

What is the child's baseline room air oximetry? ____

Does the child have splenomegaly? □ Yes □ No If Yes, spleen size ______________________

Does the child have a central venous catheter? □ Yes □ No If Yes please complete CV Catheter Form

Is the child on a chronic transfusion protocol? □ Yes □ No If Yes, how frequent? ______________________

Please provide most recent or baseline labs: Date ________________________

Hb ____________________ Hct ____________________ Retic ___________________ WBC ___________________

CXR _________________________ Date __________________________

Pain Protocol

What does the child take for:

Mild Pain ____

Moderate (increasing) Pain ____

Severe Pain ____

Children with Hemophilia: **Camper Name:____________________ Birthdate___________ Date:_______________**

What bleeding disorder does the child have?

Hemophilia A (Factor VIII deficiency) ____________ Hemophilia B (Factor IX deficiency) ________________

Other bleeding disorder ____

Severity / Factor Level ____

What brand of factor does the child use?

____

Can any other brand be used in case of emergency? □ Yes □ No If Yes please specify brand(s):

____

Is the child on prophylaxis? □ Yes □ No Does the child self infuse? □ Yes □ No

Does the child have an inhibitor or history of inhibitor? □ Yes □ No

Details:____

____

ACTIVITY PERMISSION	Yes	Pretreatment Required
Horseback Riding		
Low Ropes Adventure Program		
High Ropes Adventure Program (climbing wall with harness safety system)		

Children with Immune Disorders: **Camper Name:__________________ Birthdate___________ Date:________**

Is child aware of his or her diagnosis? □ Yes □ No Details: ____

Most recent or typical blood counts: Date ____

Hb __________ Hct __________ WBC ___________ ANC ___________ Plt _________________

CD4+ Cell Count/% _________________________________ Viral Load Copy ______________________________

Other ____

Does this child receive IVIG? □ Yes □ No

Schedule:____

Children with Metabolic Disease: **Camper Name:_________________ Birthdate___________ Date:_________**

Please explain any Dietary Restrictions:

____

____

Please explain any Activity Restrictions:

____

____

Please describe or attach on Emergency Protocol for this child:

____

____

____

Additional information:

____

____

____

CV CATHETER FORM

Complete this form only if the child has a central line (Broviac, Hickman, Portacath, etc.)

TO BE COMPLETED BY HEALTH CARE PROVIDER

All necessary supplies (dressing kits, heparin, syringes, access needles, EMLA, etc.) must be sent to Camp with child. Children will need 7 dressing kits (or equivalent supplies) if they plan on swimming every day.

Camper Name: ___________________________________ Birthdate: ____________________ Date: ____________________

Type of catheter: (External) Broviac/Hickman _____

Single lumen _____ Double lumen _____

(Internal) Portacath/ Infusaport _____

Other ____

Specific Instructions for catheter care:

How often is it flushed with heparin? ____

What amount & strength of heparin is used? ____

What size needle is used for access? ___________ gauge __________ length

How often is the dressing changed? ____

When is the cap changed? (day of the week) ____

Does this child do any or all of their own catheter care? ☐ Yes ☐ No

If Yes, please explain ____

____

May this line be used to draw blood? ☐ Yes ☐ No

What, if any, medications are to be infused into this line during the Camp period?

____

____

Special instructions: ____

____

____

CENTRAL LINE CONSENT-Unless otherwise specified, all children will be permitted to swim.

This child: ☐ DOES ☐ DOES NOT have permission to go swimming in a chlorine-treated swimming pool. (Dressings will be changed immediately following swimming)

____ ____________________________

Physician's Signature **Date**

INFUSION PUMP FORM

Complete this form only if the child uses a desferal infusion pump, TPN pump, gastrostomy feeding pump, etc

TO BE COMPLETED BY HEALTH CARE PROVIDER

You must send all supplies including medication, sterile water, needles, syringes, batteries to camp.

Camper Name: ________________________________ Birthdate: ___________________ Date: ___________________

Manufacturer and model of pump ____

Procedure to replace broken pump ____

____

Contact number for service or replacement ____

Home care company and phone number ____

Instructions for Desferal infusion pumps

Desferal dose? ____

Amount of sterile water ____

Length and rate of infusion ____

Number of nights pump is to be used at camp ______________________________________

Does this child use EMLA/ELA-MAX? Yes _______ No _______

Does this child place his/her own needle? Yes _______ No _______

Instructions for g-tube feeds or TPN

Continuous feeds/TPN:

Product and Quantity ____

Starting rate _____________ml/min X ___________ hrs (taper up)

Maint rate _____________ml/min X ___________ hrs

Ending rate _____________ml/min X ___________ hrs (taper down)

Bolus feeds

Product and Quantity ____

When is it given? ____

How is it given? (pump, gravity, push) ____

Is extra water given? Yes _______ No _______ If yes, how much and when? _______________

____

Special Instructions ____

____

____

____

THE HOLE IN THE WALL GANG CAMP

Medical Information and FAQ's

What is the medical care like at Camp?

- The infirmary is staffed by pediatric nurses and physicians 24 hours a day. They take care of your child's routine medical care and emergencies. Medical resources in the infirmary include: emergency medications, oral and IV antibiotics, IV fluids and treatment of minor emergencies. Routine and emergency blood work is drawn at camp and sent to a local hospital. If x-rays are needed they are done at a local hospital. Your insurance may be billed for these studies.

- Minor medical problems (i.e. minor cuts, ear infections, sore throats, vomiting, sprains, etc) can be handled at Camp. Emergency medical care will be given as needed (i.e. IV antibiotics for fever, pain medicines, etc). If your child becomes seriously ill, you and your child's doctor will be notified. If necessary, we will arrange transport to a local hospital. If your child is hospitalized, a parent/guardian must be prepared to travel to Connecticut to assume supervision and medical decision-making.

- We need to know about all of your child's special needs so we can provide the best care for your child. The more information we have, the better we can care for your child. Please send us all the information ahead of time so we can be ready for your child to come to Camp.

- All campers check in at the Infirmary when they arrive at Camp. You can talk with the doctors and nurses about all of your child's special needs, abilities, medications, restrictions, etc. Your child's nurse will set up a schedule for his/her routine care.

- If you have any questions regarding medical eligibility or health care needs, please contact the Medical Director or Nursing Director

What is the ratio of staff to camper and how is the counseling staff prepared for my child's arrival?

- The ratio of staff to camper is 1:2. There is a maximum of 9 children and 4 adults per cabin. Prior to your child's arrival, staff receives a thorough medical and program orientation. Also, based upon the information that is provided in your child's application, counselors receive specific information on your child's special needs, abilities, allergies, etc.

What activities does my child participate in?

- Arts & Crafts, Pottery, Woodshop, Nature, Boating & Fishing, Horseback Riding, Swimming, Discovery Zone, Photography, Music, Archery, Adventure, and Theater are among the variety of activities your child has an opportunity to experience. Your child may also have a chance to go on a "camp out" on our campgrounds if weather cooperates. Campers sleep out in tents, sing songs by the campfire and cook up the evening's dinner meal and the next morning's breakfast. These activities have been offered at Camp for many years and every precaution is taken to ensure the safety of participants. The Hole in the Wall Gang Camp does not participate in contact sports (i.e. football, hockey).

THE HOLE IN THE WALL GANG CAMP

Application Checklist

☐ **PART I**

General Information: to be completed by Parent or Guardian

a. General Information: name and contact information
b. Signed consent for medical treatment
c. Insurance Information
d. Photo release and special permissions

☐ **PART II**

Questionnaire: to be completed by Parent or Guardian

☐ **PART III**

Medical Information: to be completed by child's Medical Provider, Specialist, Primary Care Physician, or Nurse Practitioner

a. Medical Form: general medical information, medications, and immunizations
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